Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 3-7-02.
   b. The request was received on 7-1-02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFAs
   c. EOBs and Example EOBs
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. No response noted in the dispute packet.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 9-5-02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 9-10-02. No response was noted from the carrier. The "No Response Submitted" sheet is reflected in Exhibit II of the Commission's case file.

4. Notice of Additional Information submitted by Requestor, is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 8-12-02:
   "On 02-15-02, we received a prescription for the above named patient to receive a Bone Stimulator and we set up the patient….After submitting our initial claim and also our request for reconsideration, the insurance carrier only paid us $5,015.00 total for code E0747 out of $5,900.00 that were billed for these items….In summary, we strongly feel and believe that we should be reimbursed an additional $885.00 plus interest since the EOBs enclosed clearly reflect what other insurance carriers are paying as 'fair and reasonable' in our geographical area."

2. Respondent: No response noted in dispute packet.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 3-7-02.

2. The carrier denied the billed services as reflected on the EOB as, "M – No MAR/Reduced to Fair and Reasonable".

   Reaudit dated 6-25-02 reflects, "This bill has been reviewed and no further payment is due. All payments or denials are in accordance with the Texas Worker's Compensation Commission's fee guidelines and rules."

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB	MAR$	REFERENCE	RATIONALE:
3-7-02	E0747	$5900.00	$5015.00	M	DOP	MFG GI (VIII) (A); HCPCS descriptor	The modifier -NU is not recognized in the Commission's '96 MFG. For this reason, MRD is unable to determine proper reimbursement for the services in dispute. Therefore, no reimbursement is recommended.
Totals		$5900.00	$5015.00				The Requestor **is not** entitled to additional reimbursement.

The above Findings and Decision are hereby issued this 24th day of March 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll